

		FOR OHF USE					

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**2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)**

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0025577</u> Facility Name: <u>Covenant Health Care Center-Batavia</u> Address: <u>831 North Batavia Avenue</u> <u>Batavia</u> <u>60510</u> <div style="display: flex; justify-content: space-between; width: 100%;"> Number City Zip Code </div> County: <u>Kane</u> Telephone Number: <u>(630) 879-4300</u> Fax # <u>(630)879-8483</u> IDPA ID Number: <u>52-11158-73002</u> Date of Initial License for Current Owners: <u>05/09/80</u> Type of Ownership: <table border="0" style="width: 100%;"> <tr> <td><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code <u>501(c)(3)</u></td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> In the event there are further questions about this report, please contact: Name <u>Barry C. Scuttillo, CPA</u> Telephone Number: <u>954)721-5222</u>		<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code <u>501(c)(3)</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.	_____		<input type="checkbox"/> Limited Liability Co.	_____		<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER <p align="center">I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>2/1/99</u> to <u>1/31/00</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p align="center">Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width: 100%;"> <tr> <td rowspan="2" style="width: 20%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Type or Print Name) <u>Richard W. Olson</u></td> </tr> <tr> <td></td> <td>(Title) <u>Vice-President - Finance</u></td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Signed) <u>See Attached Accountant's Report</u></td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>Scuttillo & Blake, CPA, PA</u></td> </tr> <tr> <td>(Firm Name & Address) <u>8000 N. University Drive, Ft. Lauderdale, FL 33321</u></td> </tr> <tr> <td></td> <td>(Telephone) <u>(954) 721-5222</u> Fax <u>954) 722-6692</u></td> </tr> <tr> <td colspan="2"> MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630 </td> </tr> </table>	Officer or Administrator of Provider	(Signed) _____	(Date) _____		(Type or Print Name) <u>Richard W. Olson</u>		(Title) <u>Vice-President - Finance</u>	Paid Preparer	(Signed) <u>See Attached Accountant's Report</u>	(Date) _____	(Print Name and Title) <u>Scuttillo & Blake, CPA, PA</u>	(Firm Name & Address) <u>8000 N. University Drive, Ft. Lauderdale, FL 33321</u>		(Telephone) <u>(954) 721-5222</u> Fax <u>954) 722-6692</u>	MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
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DPA 3745 (N-4-99)

IL478-2471

Print Preview

Facility Name & ID Number Covenant Health Care Center-Batavia# 0025577Report Period Beginning: 2/1/99Ending: 1/31/00**III. STATISTICAL DATA**

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>128</u>	Skilled (SNF)	<u>128</u>	<u>46,848</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	<u>49</u>	Sheltered Care (SC)	<u>49</u>	<u>17,934</u>	5
6		ICF/DD 16 or Less			6
7	<u>177</u>	TOTALS	<u>177</u>	<u>64,782</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>1,168</u>	<u>656</u>	<u>1,680</u>	<u>3,504</u>	8
9	SNF/PED					9
10	ICF	<u>9,635</u>	<u>29,143</u>		<u>38,778</u>	10
11	ICF/DD					11
12	SC		<u>7,164</u>		<u>7,164</u>	12
13	DD 16 OR LESS					13
14	TOTALS	<u>10,803</u>	<u>36,963</u>	<u>1,680</u>	<u>49,446</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4 76.33%)

D. How many bed-hold days during this year were paid by Public Aid?
37 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?
YES ☒ NO ☐

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒

I. On what date did you start providing long term care at this location?
Date started 05/06/80

J. Was the facility purchased or leased after January 1, 1978?
YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number
of beds certified 16 and days of care provided 1680

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

MODIFIED
ACCRUAL ☒ CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 01/31/00 Fiscal Year: 01/31/00

* All facilities other than governmental must report on the accrual basis.

Print Preview

IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

STATE OF ILLINOIS

Page 3

Facility Name & ID Number Covenant Health Care Center-Batavia # 0025577 Report Period Beginning: 2/1/99 Ending: 1/31/00
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	380,524	49,534	(22,323)	407,735		407,735	0	407,735		1
2	Food Purchase		287,916		287,916		287,916	(49)	287,867		2
3	Housekeeping	231,300	22,133	1,995	255,428		255,428	0	255,428		3
4	Laundry	45,435	8,563	64,598	118,596		118,596	0	118,596		4
5	Heat and Other Utilities			139,183	139,183		139,183	0	139,183		5
6	Maintenance	94,751	17,942	80,707	193,400		193,400	(180)	193,220		6
7	Other (specify):*			53,219	53,219		53,219	0	53,219		7
8	TOTAL General Services	752,010	386,088	317,379	1,455,477		1,455,477	(229)	1,455,248		8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000	0	12,000		9
10	Nursing and Medical Records	2,340,098	202,708	195,464	2,738,270		2,738,270	0	2,738,270		10
10a	Therapy		1,471	98,060	99,531		99,531	0	99,531		10a
11	Activities	125,130	6,160	34,552	165,842		165,842	(1,399)	164,443		11
12	Social Services	76,644	520	73	77,237		77,237	0	77,237		12
13	Nurse Aide Training							0			13
14	Program Transportation							0			14
15	Other (specify):*							0			15
16	TOTAL Health Care and Progra	2,541,872	210,859	340,149	3,092,880		3,092,880	(1,399)	3,091,481		16
	C. General Administration										
17	Administrative	139,369	0	331,560	470,929	(17,561)	453,368	126,633	580,001		17
18	Directors Fees							0			18
19	Professional Services			63,211	63,211		63,211	0	63,211		19
20	Dues, Fees, Subscriptions & Promotions			28,296	28,296		28,296	(2,432)	25,864		20
21	Clerical & General Office Expense	237,111	12,685	61,864	311,660		311,660	(6,626)	305,034		21
22	Employee Benefits & Payroll Taxes			674,041	674,041	17,561	691,602	0	691,602		22
23	Inservice Training & Education							0			23
24	Travel and Seminar			10,954	10,954		10,954	(6,626)	4,328		24
25	Other Admin. Staff Transportation							0			25
26	Insurance-Prop.Liab.Malpractice			15,894	15,894		15,894	0	15,894		26
27	Other (specify):*							0			27
28	TOTAL General Administration	376,480	12,685	1,185,820	1,574,985		1,574,985	110,949	1,685,934		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,670,362	609,632	1,843,348	6,123,342		6,123,342	109,321	6,232,663		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Print Preview

IF AN ERROR OCCURS IN LINE 37 OR 44, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

STATE OF ILLINOIS

Page 4

Facility Name & ID Number Covenant Health Care Center-Batavia # 0025577 Report Period Beginning: 2/1/99 Ending: 1/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			184,693	184,693		184,693	14,387	199,080		30
31	Amortization of Pre-Op. & Org.							0			31
32	Interest			426,251	426,251		426,251	(421,620)	4,631		32
33	Real Estate Taxes			16,260	16,260		16,260	(16,260)			33
34	Rent-Facility & Grounds							0			34
35	Rent-Equipment & Vehicles			3,884	3,884		3,884	0	3,884		35
36	Other (specify):*							0			36
37	TOTAL Ownership			631,088	631,088		631,088	(423,493)	207,595		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation							0			38
39	Ancillary Service Centers	80,156	273,842	4,328	358,326		358,326	0	358,326		39
40	Barber and Beauty Shops			47,153	47,153		47,153	0	47,153		40
41	Coffee and Gift Shops							0			41
42	Provider Participation Fee							70,080	70,080		42
43	Other (specify):*		157	18,295	18,452		18,452	(18,452)			43
44	TOTAL Special Cost Centers	80,156	273,999	69,776	423,931		423,931	51,628	475,559		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,750,518	883,631	2,544,212	7,178,361	0	7,178,361	(262,544)	6,915,817		45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Print Preview

FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

STATE OF ILLINOIS

Page 5

Facility Name & ID Number Covenant Health Care Center-Batavia

0025577

Report Period Beginning: 2/1/99

Ending: 1/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1 Amount	2 Refer- ence	3 OHF USE ONLY	
	NON-ALLOWABLE EXPENSES				
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Program:				3
4	Non-Patient Meals	(49)	2		4
5	Telephone, TV & Radio in Resident Rooms	(6,626)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	14,387	30		9
10	Interest and Other Investment Income	(437,754)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(29,215)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (459,257)		\$	30

OHF USE ONLY

48		49		50		51		52	
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B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below. (See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	126,633	17	34
35	Other- Attach Schedule Participation Fee	70,080	42	35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 196,713		36
	(sum of SUBTOTALS)			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (262,544)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference
38	Medically Necessary Transport		N	\$	38
39					39
40	Gift and Coffee Shops		N		40
41	Barber and Beauty Shops		N		41
42	Laboratory and Radiology		N		42
43	Prescription Drugs		N		43
44	Exceptional Care Program		N		44
45	Other-Attach Schedule		N		45
46	Other-Attach Schedule		N		46
47	TOTAL (C): (sum of lines 38-46)			\$	47

Print Preview

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.

IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Summary A

Facility Name & ID Numb Covenant Health Care Center-Batavia

0025577 Report Period Beginning:

2/1/99

Ending: 1/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary
A

Operating Expenses		PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
A. General Services														
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(49)	0	0	0	0	0	0	0	0	0	0	(49)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(180)	0	0	0	0	0	0	0	0	0	0	(180)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(229)	0	0	0	0	0	0	0	0	0	0	(229)	8
B. Health Care and Programs														
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(1,399)	0	0	0	0	0	0	0	0	0	0	(1,399)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Program	(1,399)	0	0	0	0	0	0	0	0	0	0	(1,399)	16
C. General Administration														
17	Administrative	126,633	0	0	0	0	0	0	0	0	0	0	126,633	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(2,432)	0	0	0	0	0	0	0	0	0	0	(2,432)	20
21	Clerical & General Office Expenses	(6,626)	0	0	0	0	0	0	0	0	0	0	(6,626)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(6,626)	0	0	0	0	0	0	0	0	0	0	(6,626)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	110,949	0	0	0	0	0	0	0	0	0	0	110,949	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	109,321	0	0	0	0	0	0	0	0	0	0	109,321	29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

**SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.**

STATE OF ILLINOIS

Summary B

Facility Name & ID Number: Covenant Health Care Center-Batavia

0025577

Report Period Beginning:

2/1/99

Ending:

1/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary
B

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	14,387	0	0	0	0	0	0	0	0	0	0	14,387	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(421,620)	0	0	0	0	0	0	0	0	0	0	(421,620)	32
33	Real Estate Taxes	(16,260)	0	0	0	0	0	0	0	0	0	0	(16,260)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(423,493)	0	0	0	0	0	0	0	0	0	0	(423,493)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	70,080	0	0	0	0	0	0	0	0	0	0	70,080	42
43	Other (specify):*	(18,452)	0	0	0	0	0	0	0	0	0	0	(18,452)	43
44	TOTAL Special Cost Centers	51,628	0	0	0	0	0	0	0	0	0	0	51,628	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(262,544)	0	0	0	0	0	0	0	0	0	0	(262,544)	45

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REI

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees)
**FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
 ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION**

Print Preview

| the name(s)
PORTS.

Facility Name & ID Number Covenant Health Care Center-Batavia# 0025577 Report Period Beginning: 2/1/99Ending: 1/31/00VIII. ALLOCATION OF INDIRECT COSTS A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Covenant Retirement Communities, Inc.
 Street Address 5115 N. Francisco Avenue, Suite # 200
 City / State / Zip Code Chicago, Illinois, 60625
 Phone Number (773) 878-2294
 Fax Number (773) 878-2289

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	Management Fees	Actual Net Service		\$	\$		\$	1
2		Revenue	88,309,000	32	4,428,360	1,522,495	12,787,591	331,560	2
3	19	Data Processing	Fixed Per Month(1)	32	331,452	Not Available	1	17,688	3
4	19	Auditing Services	Fixed Per Month(2)	32	319,747	0	1	11,213	4
5	19	Cost Report Preparation	Fixed Per Month(3)	14	55,968	0	1	5,496	5
6	19	Payroll Services	Dir. Cost From Vendor	1	10,384	0	1	10,384	6
7	22	Pension Expense	Fixed Per Month(4)	32	519,466	0	1	50,556	7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19		Note:							19
20		(1) Data Processing is based upon a fixed fee of \$1,474 / month.							20
21		(2) Auditing Services are based upon a fixed fee of \$934/ month.							21
22		(3) Cost Report preparation services are based upon a fixed fee of \$458/ month.							22
23		(4) Pension plan expenses are based upon an estimated fee of \$4,213/ month.							23
24									24
25	TOTALS				\$ 5,665,377	\$ 1,522,495		\$ 426,897	25

Print Preview

Facility Name & ID Number Covenant Health Care Center-Batavia

0025577

Report Period Beginning:

2/1/99

Ending:

1/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1	See supplementary schedule I						\$ 7,385,064	\$ 6,219,742			\$ 362,164	1	
2	See supplementary schedule II						255,269	178,636			64,087	2	
3												3	
4												4	
5												5	
	Working Capital												
6	Interco. Notes To/From CRC/CB											6	
7	Michealsen	XX		Working Capital	O/S Balance	02/01/94	(2,472,340)	(5,945,821)	n/a	Variable		7	
8	Colonial House	XX		Working Capital	O/S Balance	02/01/94	(1,208,060)	(1,454,158)	n/a	Variable		8	
9	TOTAL Facility Related						\$ 3,959,933	\$			\$ 426,251	9	
	B. Non-Facility Related*												
10	Interest Income Offset										(437,754)	10	
11												11	
12	Amort of Loss on EE of Debt										16,134	12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 3,959,933	\$			\$ 426,251	15	

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

Print Preview

Facility Name & ID Number: **Covenant Health Care Center-Batavia**# **0025577**

Report Period Beginning:

2/1/99

Ending:

1/31/00**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 1999 report.	\$	13,262	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	14,416	2
3. Under or (over) accrual (line 2 minus line 1).	\$	1,154	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	15,106	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	\$	16,260	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1995		8
	1996		9
	1997		10
	1998	14,166	11
	1999	12,299	12

Current year accrual is based on a percentage of payments made for the prior year. Result is adjusted up or down, based on estimated of any extraordinary events expected to take place.

FOR OFF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 1999	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATIC	\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

Print Preview

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 36,884 B. General Construction Type: Exterior Masonry - Brick Frame _____ Number of Stories _____

C. Does the Operating Entity? ☒ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☒ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

The Holmstad is a residential independent living facility for senior adults: 302,869 square feet and 318 units.

Park Manor is a division of the residential independent living facility which has assisted services for senior adults: building F(44 out of 64 apartments in building F) and 44 units.

Colonial House is licensed for 49 beds sheltered care facility: 29,647 square feet and 27 rooms.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1			1979-1980	\$ 86,624	1
2					2
3	TOTALS			\$ 86,624	3

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE
REMOVE THE TEXT FROM COLUMN 2 OR 3.

Show Pgs 12A & 12B

Show Pgs 12C and 12D

Hide Pgs 12A thru 12D

STATE OF ILLINOIS

Page 12

Facility Name & ID Number Covenant Health Care Center-Batavia

0025577

Report Period Beginning:

2/1/99

Ending:

1/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	128		1980	1980	\$ 2,454,000	\$ 76,388	33	\$ 74,364	\$ (2,024)	\$ 1,449,726	4
5	49		1977	1977	818,006	24,535	33	24,788	253	550,794	5
6											6
7											7
8											8
	Improvement Type**										
9	Building Improvements										
10	Michealsen (See 12a for details)				389,213	21,872	See 12a	34,948	13,076	244,712	10
11	Colonial House (See 12c for details)				121,816	2,817	See 12c	5,204	2,387	89,190	11
12											
13	Land Improvements										
14	Michealsen (See 12b for details)				258,880	16,597	See 12b	15,844	(753)	230,099	14
15	Colonial House (See 12d for details)				6,036	302	See 12d	302		3,044	15
16											
17											
18											
19											
20											
21											
22											
23											
24											
25											
26											
27											
28											
29											
30											
31											
32											
33											
34											
35											
36	TOTAL (lines 4 thru 35)				\$ 4047951	\$ 142,511		\$ 155,450	\$ 12,939	\$ 2,567,565	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE
REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12A

STATE OF ILLINOIS

Page 12A

Facility Name & ID Numbe Covenant Health Care Center-Batavia

0025577

Report Period Beginning:

2/1/99

Ending:

1/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Building Improvements - Michealsen			1982	8,904	145	30	297	152	4,995	9
10				1983	17,320	532	30	577	45	9,287	10
11				1984	1,040		10	0		1,040	11
12				1988	9,128		10			9,128	12
13				1989	18,984	761	10	953	192	18,984	13
14				1990	40,083	4,008	10	4,008		38,076	14
15				1991	18,354	1,835	10	1,836	1	15,606	15
16				1992	18,931	1,893	10	1,893		14,198	16
17				1993	90,076	4,504	10	9,008	4,504	58,552	17
18				1994	56,935	2,847	10	5,694	2,847	31,317	18
19				1995	84,370	4,219	10	8,438	4,219	37,971	19
20	Window treatment			1996	9,675	484	10	967	483	3,385	20
21	Cubicle Curtain			1997	544	27	10	54	27	159	21
22	Door			1997	378	19	10	38	19	93	22
23	Cubicle Curtain			1997	3,495	175	10	350	175	744	23
24	Cubicle Curtain			1997	153	8	10	15	7	44	24
25	Locks for lockers			1998	1,514	138	10	151	13	302	25
26	Awnings for patio			1998	1,428	64	10	143	79	212	26
27	Awnings for patio			1998	1,428	44	10	143	99	191	27
28	Cafe wallpaper			1998	852	30	10	85	55	117	28
29	Permit for UST installation			1998	528	12	10	53	41	66	29
30	Kitchen Renovation			1999	912	50	10	87	37	87	30
31	Kitchen Renovation-Counter			1999	1,269	35	10	71	36	71	31
32	Awnings			1999	938	16	10	34	18	34	32
33	Awnings			1999	938	13	10	26	13	26	33
34	Smoking Area Recepticles			1999	467	6	10	12	6	12	34
35	Window Cornice			1999	569	7	10	15	8	15	35
36	TOTAL (lines 4 thru 35)				\$ 389,213	\$ 21,872		\$ 34,948	\$ 13,076	\$ 244,712	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

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IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE
REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12B

STATE OF ILLINOIS

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Facility Name & ID Number Covenant Health Care Center-Batavia

0025577

Report Period Beginning:

2/1/99

Ending: 1/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Land Improvements - Michealsen			1980	195,783	14,779	20	12,689	(2,090)	193,786	9
10				1982	780	39	20	39		653	10
11				1986	14,644		20	732	732	10,184	11
12				1987	12,022		20	601	601	7,925	12
13				1988	1,368	68	20	68		876	13
14				1989	520	32	20	26	(6)	312	14
15				1989	17,748	827	20	888	61	9,324	15
16				1990	4,592	155	20	230	75	2,185	16
17				1991	11,423	697	20	571	(126)	4,854	17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				\$ 258880	\$ 16,597		\$ 15,844	\$ (753)	\$ 230,099	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE
REMOVE THE TEXT FROM COLUMN 2 OR 3.

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Facility Name & ID Numbe Covenant Health Care Center-Batavia

0025577

Report Period Beginning:

2/1/99 Ending: 1/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Building Improvements - Colonial House			1982	4,198	148	30	140	(8)	2,589	9
10				1983	657	24	30	22	(2)	383	10
11				1984	208		10	0		208	11
12				1986	29,215		10			29,215	12
13				1987	21,856		10			21,856	13
14				1988	11,310		10			11,310	14
15				1990	4,698	247	10	235	(12)	4,698	15
16				1991	1,227	123	10	123		1,167	16
17				1992	2,991	299	10	299		2,542	17
18				1994	7,673	384	10	767	383	4,987	18
19				1995	150	7	10	15	8	82	19
20	Carpeting			1996	18,620	931	10	1,862	931	7,205	20
21	Drapes			1997	1,883	94	10	188	94	551	21
22	Carpeting			1997	210	11	10	21	10	62	22
23	Carpeting			1997	537	27	10	54	27	145	23
24	Carpeting			1997	2,511	126	10	251	125	674	24
25	Bathroom Tile			1997	139	7	10	14	7	37	25
26	Carpeting			1997	1,331	66	10	133	67	346	26
27	Carpeting			1997	245	12	10	24	12	61	27
28	Drapes			1998	203	10	10	20	10	34	28
29	Permit for UST installation			1998	72	4	10	7	3	9	29
30	Drapes			1999	10,490	272	10	977	705	977	30
31	Carpeting			1999	256	11	10	22	11	22	31
32	Carpeting			1999	450	14	10	28	14	28	32
33	Floor Covering			1999	244		10	1	1	1	33
34	Toilet			1999	174		10	1	1	1	34
35	Floor Covering			2000	268		10				35
36	TOTAL (lines 4 thru 35)				\$ 121,816	\$ 2,817		\$ 5,204	\$ 2,387	\$ 89,190	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE
REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12D

STATE OF ILLINOIS

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Facility Name & ID Numbe Covenant Health Care Center-Batavia

0025577

Report Period Beginning:

2/1/99 Ending: 1/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Land Improvements - Colonial House			1990	3,528	177	20	177		1,853	9
10				1991	2,508	125	20	125		1,191	10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				\$ 6,036	\$ 302		\$ 302	\$	\$ 3,044	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

Facility Name & ID Number Covenant Health Care Center-Batavia

0025577

Report Period Beginning:

2/1/99

Ending:

1/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Componen Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$ 392,049	\$ 39,318	\$ 40,766	\$ 1,448	10	\$ 210,555	37
38	Current Year Purchases	56,713	2,864	2,864		10	2,864	38
39	Fully Depreciated Assets	488,768				10	488,768	39
40								40
41	TOTALS	\$ 937,530	\$ 42,182	\$ 43,630	\$ 1,448		\$ 702,187	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Patient Transportation	Ford Van - 1984	1984	\$ 30,198	\$	\$	\$		\$ 30,198	42
43										43
44										44
45										45
46	TOTALS			\$ 30,198	\$	\$	\$		\$ 30,198	46

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ 5,102,303	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 184,693	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 199,080	49
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ 14,387	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 3,299,951	51

**

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		\$	\$	\$	52
53					53
54					54
55					55
56					56
57	TOTALS	\$	\$	\$	57

G. Construction-in-Progress

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

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XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

☐ YES ☒ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34. _____

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: ☐ YES ☒ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipm: \$ 3,884 Description: Equipment Rental (Sch V, Line 35)

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>N/A</u>		\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2001 \$ _____

13. /2002 \$ _____

14. /2003 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

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Facility Name & ID Number Covenant Health Care Center-Batavia

#

0025577Report Period Beginning: 2/1/99Ending: 1/31/00**XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)****A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)**1. HAVE YOU TRAINED AIDES
DURING THIS REPORT
PERIOD?☐ YES☒ NOIf "yes", please complete the remainder
of this schedule. If "no", provide an
explanation as to why this training was
not necessary.2. CLASSROOM PORTION:IN-HOUSE PROGRAM ☐IN OTHER FACILITY ☐COMMUNITY COLLEGE ☐

HOURS PER AIDE _____

3. CLINICAL PORTION:IN-HOUSE PROGRAM ☐IN OTHER FACILITY ☐

HOURS PER AIDE _____

B. EXPENSES**ALLOCATION OF COSTS (d)**

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

C. CONTRACTUAL INCOMEIn the box below record the amount of income your
facility received training aides from other facilities\$ **D. NUMBER OF AIDES TRAINED**

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(e) The total amount of Drop-out and Completed Costs for
your own aides must agree with Sch. V, line 13, col. 8.(f) Attach a schedule of the facility names and addresses
of those facilities for which you trained aides.

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ies.

Facility Name & ID Number Covenant Health Care Center-Batavia# 0025577

Report Period Beginning:

2/1/99

Ending:

1/31/00

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

1		2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A	hrs	\$	243	\$ 18,569	\$	243	\$ 18,569	1
2	Licensed Speech and Language Development Therapist	10A	hrs		19	1,951		19	1,951	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A	hrs		932	72,839		932	72,839	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39	# of prescripts		15,174		265,229	15,174	265,229	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Lab & X-ray	39			231	4,328		231	4,328	13
14	TOTAL			\$	16,599	\$ 97,687	\$ 265,229	16,599	\$ 362,916	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

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Facility Name & ID Number Covenant Health Care Center-Batavia

0025577

Report Period Beginning: 2/1/99

Ending:

1/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 1/31/00

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 171,020	\$ 11,692,000	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	412,209	8,441,000	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments		11,922,000	5
6	Prepaid Insurance	7,653		6
7	Other Prepaid Expenses		576,000	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 590,882	\$ 32,631,000	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments		#####	12
13	Land	423,734	17,927,000	13
14	Buildings, at Historical Cost	3,893,667	#####	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	496,759	37,334,000	16
17	Accumulated Depreciation (book methods)	(2,886,309)	#####	17
18	Deferred Charges	178,635		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	1,281,013	71,342,000	21
22	Other Long-Term Assets (specify):		20,857,000	22
23	Other(specify): Construction in Progress	46,077	32,874,000	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,433,576	\$ #####	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,024,458	\$ #####	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 88,970	\$ 8,757,000	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits		7,810,000	28
29	Short-Term Notes Payable		4,685,000	29
30	Accrued Salaries Payable	282,150	4,449,000	30
31	Accrued Taxes Payable (excluding real estate taxes)	10,441		31
32	Accrued Real Estate Taxes(Sch.IX-B)	33,794		32
33	Accrued Interest Payable	59,650	1,737,000	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	12,065	7,160,000	36
37	Current Maturities - Long Term Debt	129,481	5,390,000	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 616,551	\$ 39,988,000	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	6,090,261		40
41	Bonds Payable		#####	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Intercompany Accts, Other Liabilities	(7,379,207)	7,913,000	43
44	Deferred Revenue		#####	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ (1,288,946)	\$ #####	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ (672,395)	\$ #####	46
47	TOTAL EQUITY(page 18, line 24)	\$ 4,696,853	\$ 63,687,000	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,024,458	\$ #####	48

*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,422,436	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,422,436	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	243,256	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) <u>Designated Contributions</u>	31,906	15
16	Other (describe) <u>Planned Giving Assessment</u>	(745)	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 274,417	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 4,696,853	24 *

* This must agree with page 17, line 47.

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Facility Name & ID Number Covenant Health Care Center-Batavia

0025577

Report Period Beginning: 2/1/99

Ending:

1/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 7,085,658	1
2	Discounts and Allowances for all Levels	(1,202,654)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,883,004	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	435,677	6
7	Oxygen	16,080	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 451,757	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	58,306	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	6,626	15
16	Rental of Facility Space		16
17	Sale of Drugs	297,158	17
18	Sale of Supplies to Non-Patients	188,667	18
19	Laboratory	6,504	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	71,009	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 628,270	23
D. Non-Operating Revenue			
24	Contributions	100	24
25	Interest and Other Investment Income***	437,754	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 437,854	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Equipment Rental	13,010	28
28a	See Attached List	7,722	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 20,732	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,421,617	30

2			
Expenses		Amount	
A. Operating Expenses			
31	General Services	\$ 1,455,477	31
32	Health Care	3,092,880	32
33	General Administration	1,574,985	33
B. Capital Expense			
34	Ownership	631,088	34
C. Ancillary Expense			
35	Special Cost Centers	423,931	35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,178,361	40
41	Income before Income Taxes (line 30 minus line 40)**	243,256	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 243,256	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

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